Slovakia

Health Care & Long-Term Care Systems

An excerpt from

the Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability,

published in June 2019
as Institutional Paper 105
Country Documents - 2019 Update

Economic and Financial Affairs
Economic Policy Committee

Slovakia

Health care systems

From: *Joint Report on Health Care and Long-Term Care Systems and Fiscal Sustainability*, prepared by the Commission Services (Directorate-General for Economic and Financial Affairs), and the Economic Policy Committee (Ageing Working Group), Country Documents – 2019 Update

2.24. SLOVAKIA

General context: Expenditure, fiscal sustainability and demographic trends

General country statistics: GDP, GDP per capita; population

GDP per capita in PPS in Slovakia is at 21,600 and below EU average of 29,600 in 2015. Slovakia's current population stands at 5.4 million people in 2015 and has been fairly stable throughout the decade. The projections reveal a decrease from 5.4 million people in 2016 to 4.9 million in 2070.

Total and public expenditure on health as % of GDP

Total expenditure on health as a percentage of GDP (7.0% in 2015) is below the EU average (10.2%). It has increased from 5.4% in 2003, but is lower than that registered peak in 2009 (8.5% of GDP) and decreased by 1.1 pps only in a year. Total public expenditure on health as a percentage of GDP is below the EU average (in 2015 it was 5.6% compared to 8.0% in the EU). Looking at health care without long-term care ([322]) reveals a similar picture with public spending below the EU average (5.6% vs. 6.8% in 2015). Total (1,556 PPS in 2015) and public (1,246 PPS in 2015) per capita expenditure are lower than the EU average (3305 PPS and 2,609 PPS) ([323]).

Expenditure projections and fiscal sustainability

Public expenditure on health care is projected to increase by 1.2 pps of GDP ("AWG reference scenario"), much above the average increase of 0.9 pps for the EU. When taking into account the impact of non-demographic drivers on future spending growth ("AWG risk scenario"), health care expenditure is expected to increase by 2.6 pps of GDP from now till 2070 compared to the EU average of 1.6 pps ([324]).

Over the long run, medium fiscal sustainability risks appear for the Slovak Republic. These risks derive primarily from the projected impact of age-related public spending (notably healthcare and pensions) ([325]).

Health status

Despite showing an improvement, the health status of the Slovak population lags slightly behind the EU average. While showing a consistent increase, life expectancy (80.2 years for women and 73.1 years for men in 2015) is still below the EU average (83.3 for women and 77.9 for men). So are healthy life years (55.1 years for women and 54.8 years for men in 2015 vs. EU average of 63.3 and 62.6 respectively), which have been interestingly showing a decreasing trend after 2007, only to start picking up again over the recent years. Amenable mortality rates show a consistent decrease over the decade but are still fairly high notably compared to other countries of similar GDP per capita (e.g. 250 per 100,000 inhabitants in Slovakia for 2015 and 127 in the EU). Infant mortality is also above the EU average (5.1‰ vs. 3.6‰ in 2015).

System characteristics

System financing, revenue collection, population coverage and role of private insurance and out-of-pocket payments

The Slovak health care system is a compulsory social health insurance scheme covering all residents. In practice, a small share of the population (about 4% in 2011) ([326]) does not pay the required contributions ([327]) and is not covered if they are not entitled to automatic membership ([328]). Insured persons are allowed to choose health insurance fund among three health insurance companies. The State pays the contributions of some population groups (dependent children,

([322]) To derive this figure, the SHA aggregate HC.3 for LTC (health) is subtracted from total health spending.

([323]) Note that these PPS figures reflect current plus capital health expenditure in contrast to EUROSTAT data series, which reflect current expenditure only.

([324]) The 2018 Ageing Report, https://ec.europa.eu/info/sites/info/files/economy-finance/ip079_en.pdf.

([325]) European Commission, Fiscal Sustainability Report (2018), https://ec.europa.eu/info/sites/info/files/economy-finance/ip094_en_vol_2.pdf.

([326]) Source: http://www.udzs-sk.sk/documents/14214/21128/Sprava_o+stave+vykonavania+VZP_2014_final.pdf/d1948cc6-023c-4529-be7d-15022d29f5ea.

([327]) For all the economically inactive people health contributions are paid by the state. The aforementioned 4% comprises of the self-payers, self-employed persons and employers who do not pay the required insurance even though they should.

([328]) Old-age pensioners, persons on early retirement or those receiving a disability pension whose degree of incapacity is 70% or more.

pensioners, persons taking care of children aged up to 3 years, all students up to the age of 26, full-time postgraduate students up to the age of 30, PhD students and other groups) to ensure their coverage.

Public health insurance is assured by three health insurance companies (HICs), one of which is state-owned and two of which, have the form of private joint stock companies. The market is dominated by the state-owned company, whose share amounts to 63% of the total insurers in 2016 ([329]).

Mandatory insurance contributions vary according to groups: 14% of the gross monthly earning for employees (employers pay 10% and employees 4%, 7 % for disabled persons (the self-employed pay 7%, and for the employed the employer pays 5% and employee pays 2%) and self-employed. The minimum assessment base for the groups equal the average wage divided by two. The contributions paid by the State on behalf of some population groups (dependent children, pensioners, persons taking care of children aged up to 3 years) amounted to 4.4% of the average wage in 2016.

In 2015, the Government approved a reform of the social protection contributions to incentivise low-wage labour supply and demand. It includes a health contribution allowance (HCA), for an income up to €380, which was equal to the minimum wage in 2015, though the allowance is fixed to this amount and is not supposed to be automatically adjusted to the increase in minimum wage. For an income above the €380 up to €570 per month, the health contribution allowance gradually decreases. Deductible allowances are only applicable for income from employment, while when determining the entitlement other revenues are also considered. The cash shortfall of revenue of HICs (amounting to 0.21 % of the GDP in 2015) was compensated from the state budget.

Moreover, a risk equalisation scheme has been introduced by the State which can redistribute companies' revenues in order to compensate between insurance companies for the existing demographic and socio-economic differences of the insured. Redistribution criteria include sex, age, costly chronic diseases (so called Pharmacy Cost Groups) and the number of policyholders whose contribution is paid by the State ([330]). New schemes will be introduced in 2019. Especially the Multiple-Year High Cost (MYHC) groups, which additionally redistribute the risk among cost-similar policyholders.

In 2015, 68% of total health expenditure funding came from mandatory health contributions plus 6.7% government sources (direct and indirect taxes collected centrally). The remaining part is private expenditure on health including private health insurance and out-of-pocket payments. A large part of private expenditure is out-of-pockets (though not necessarily cost-sharing for publicly goods and services as explained below) which represent 18.4% of total expenditure on health (EU average of 15.9% in 2015). This is nevertheless lower than in previous years.

Small lump-sum fees (co-payments) for many medical services and goods were introduced in 2003 with the aim of controlling consumption but in 2006 most of them were abolished (primary and specialist outpatient care, hospital stays) or considerably lowered (prescriptions for medicines). Following the changes in 2006, various payments were introduced by individual healthcare providers. In 2015, the government passed legislation to regulate payments by banning e.g. payments for appointments at a scheduled time. However, the media have since reported that new payments have been introduced to bypass the legislation ([331]). In addition to cost-sharing for medicines, fees apply to emergency services, ambulance transportation and spa treatment. A small number of services (e.g. in dental care ([332]) and cosmetic surgery) are not covered. The aim of introducing fees was to limit excess demand and ensure a coherent path of care. However, there were concerns for the already high private expenditure and they were abolished. Note that in addition to formal out-of-pockets there are persistent, considerable and unmeasured informal payments. These are not adjusted to individual

([329]) Source: http://www.udzs-sk.sk/documents/14214/92018/VE_11_2018_sprava_stav+VZP_2017.pdf/c5568cdb-9177-4db6-be25-86fd82bc9425.

([330]) http://www.zakonypreludi.sk/zz/2004-580.

([331]) http://www.health.gov.sk/?poplatky-v-zdravotnictve.

([332]) Standard dental care is covered, but the use of non-standard materials is not: https://www.vszp.sk/poistenci/zdravotna-starostlivost/kedy-platit-za-zdravotnu-starostlivost.html or http://www.dovera.sk/najcastejsie-otazky/a295/co-mi-preplatite-u-zubara.

socio-economic characteristics, so they can have a negative impact on access and discourage a more effective use of services. The design of cost-sharing is an area that may require further policy analysis.

The share of voluntary private health insurance of total current health expenditure in 2015 was only 1.8%. Private health insurance in Slovakia has mostly a supplementary function covering non-essential services not provided under social health insurance.

The State defines annually health care expenditure targets for different health services but overshooting is possible. The State can influence the volume of funds available to the HIC. Furthermore, it can influence spending through regulation in particular areas (e.g. price-setting for medical rescue services). However, on the whole, it is up to the HIC to decide on healthcare spending.

Administrative organisation: levels of government, levels and types of social security settings involved, Ministries involved, other institutions

The Ministry of Health develops the national health policy strategy, defines public health and policy priorities and provides the overall management of the health care system as a whole. The Ministry of Health and the Office for the Supervision of Health Care regulate and supervise the activity of the health insurance companies.

The contracts between HIC and inpatient and outpatient providers regulate only the mandatory list of services covered by public health insurance, whereas prices and detailed conditions are negotiable without regulation. The network of strategic public healthcare providers and general practitioners are privileged ([333]) as HIC are obliged to sign contracts with all these hospitals and their departments. Other providers or certain types of their services may be omitted from contracting. Reimbursement of pharmaceuticals is regulated via a specified list of medicines with fixed prices and reimbursement levels.

There are constrains on the health insurance companies' use of profits made from public insurance and payments for health care provision. In 2007, the government banned the use of profits to pay dividends. In 2011, the Constitutional court found this was not in line with the Constitution. As of 2011, HICs may again use profits to pay dividends. However, conditions apply, that is before paying out dividends, HIC must create 1.reserves for the provision of planned healthcare (i.e. healthcare to be provided to patients on waiting lists) and 2. a separate reserve fund at least to the value of 20 % of common capital stock.

Coverage of services, types of providers, referral systems and patient choice

A wide range of health care services and goods is provided through a network of private and publicly owned facilities contracted by insurance companies: primary health care, outpatient specialist consultations and hospital care (day-case and inpatient), emergency and transporting medical services, and a range of related services including imaging diagnostic services, laboratories ([334]), physiotherapy, dialysis care, home nursing agencies and hospices. Health insurance companies have to contract all general practitioners and pharmacies and a specified minimum number of specialists and hospitals.

The provision of health care is decentralised and based on a public-private mix. Public and private health care providers sign contracts with the health insurance companies in order to be eligible for reimbursement. General practitioners (GPs) and outpatient specialists can be independent private providers or public providers. Most private

([333]) These healthcare providers (HCPs) were selected by the government as "strategic providers". The majority is public, however a growing proportion is privately owned. HICs are obligated to conclude contracts with these HCPs, no matter what the quality of their service provision is. This makes strategic providers privileged compared to non-strategic HCPs. Only hospitals have been designated strategic, not GPs.

([334]) A comparison of spending data among EU countries (based on available Eurostat data) shows that per capita spending on laboratories and diagnostic imaging in Slovakia is higher than the EU average level, 70 and 40 PPS per inhabitant respectively in 2015. The average spending of Hungary, Poland and the Czech Republic is significantly lower and well below the EU average. Similarly, spending on transportation and medical rescue services in Slovakia is with 40 PPS per capita above the EU average (30 PPS per capita), though comparable with the spending in Poland and the Czech Republic in 2015.

primary care providers have contracts with health insurance companies. Only some private primary care providers such as dentists are working on the basis of direct payments from patients and without a contract with health insurance companies. There is some current policy discussion on encouraging group practices rather than individual practices.

Patients have to register with a GP whom they can choose freely. A so-called "exchange card", introduced in 2008, works as a referral tool from a GP to a specialist or hospital. The aim is to have GPs referring patients for specialist care, operating as gate-keepers. Since 1 April 2013, the GP referral system is in operation again, after it was abolished in 2010. However, the system does not work for all specialties (e.g. accident and emergency, chronic care, outpatient psychiatric care, dentists, ophthalmologists, dermatologists and gynaecologists are exempted) and it does not appear to be very effective due to shortages of GPs especially in certain areas ([335]). This is something the authorities see as a policy priority.

Secondary and tertiary care are provided in a number of general and specialised hospitals, polyclinics, hospices and nursing homes. The ownership and management of most public institutions has been decentralised from central to regional level. The 2007 reform introduced healthcare districts, whereby all GPs, gynaecologists and dentists are obliged to provide care to each patient resident in their respective territorial districts, who in turn has the right to choose freely his/her physician. Moreover, a minimum network of public health care providers was established (including 37 hospitals, a part of which is now privately owned) ([336]), which have to be contracted by the health care companies. While choosing the providers beyond the list of minimum public network each fund could establish its own evaluation criteria. The government adopted an official list of indicators to assess the quality of providers.

In case of out-patient medical treatment, there is direct access to the primary care physician contracted by the health insurance company (information about the contracted physicians shall be provided by each of the health insurance companies). If the specialist outpatient care is needed, the referral of primary care physician is requested. Patients do not pay for the specialist outpatient care provided ([337]). When hospitalisation is needed, the referral of GPs is requested except in case of immediate hospitalisation. In this case the patient does not have to pay a fee for the health care provided.

There is direct access to the contracted dentist (information on the contracted dentists shall be provided by each health insurance company). There is a "standard" dental treatment which is reimbursed by the public health insurance. The price difference for additional treatment or above-standard is paid by the patient. The price of non-standard treatment is determined by each dental practice and varies between clinics. The dentist is obliged to inform the patient in advance about the expenses for services with private co-payment and about the expenses of direct payment and in what amount.

User fees are applied to emergency care, differentiating between outpatient and hospital emergency care. In the case of hospital emergency care (Medical First Aid or Hospital Emergency Service) a fee of €10 applies to all patients, except to those who had an immediate accident or had been hospitalised on the grounds of the emergency health condition. Conversely, the fee for outpatient emergency care is €2 and is meant to serve patients with non-acute health problems.

Some primary and specialist outpatient care also take place in specialists' private individual or group practices and some hospital care takes in private clinics and hospitals at the cost of patient.

The number of practicing physicians per 100,000 inhabitants (345 in 2015) is at the EU average (344 in 2015). The number of GPs per 100,000 inhabitants (42 in 2007, latest available data) is also below EU average (78.3 in 2015). The numbers suggest that the skill mix may need to

([335]) In 2014, the government introduced a residential program to facilitate the training of GPs and paediatricians for rural areas (http://www.health.gov.sk/?rezidenti). The aim is to train 100-150 doctors a year (http://www.health.gov.sk/?faq-rezidenti).

([336]) https://www.vszp.sk/poistenci/zdravotna-starostlivost/pevna-siet-poskytovatelov-k-1-1-2016.html.

([337]) In practice, fees may apply. Fees are mostly related to accompanying services and administrative steps.

improve to ensure a good distribution of GPs, currently deemed unequal by the authorities, and the effectiveness of the referral system and the GPs' gatekeeping role which the authorities want to reinforce. Indeed, this is one of the policy priorities of the Slovak authorities with the introduction of the residential programme for GPs. Acute hospital beds stand at 488 per 100 000 inhabitants and are higher than the EU average of 402 per 100 000 inhabitants in 2015, though showing a reduction over the last decade.

A next consideration to be made is the existence of staff supply regulations. As it turns out, there are no quotas for medical students as the pool of graduated medical students through the entire hierarchy is sufficient. The location of physicians is partially managed by HICs since each HIC manages its own minimal network of physicians depending on the geographical density of their clients. Specialists in locations with fewer patients have more convenient contracts.

Purchasing and contracting of healthcare services and remuneration mechanisms

Primary care physicians are paid mainly on a capitation basis. Specialists are paid on a fee-for-service basis. The current system of financing health care is based on a combination of a point and fixed price system. For outpatient care, each medical service has a point value listed by the Slovak Ministry of Health. As the list of medical services with assigned point values is not being updated regularly and new services/ procedures are being introduced, HICs now set fixed prices for these, rather than setting a point value.

Assessing and adjusting hospital remuneration is something the authorities have indicated as a policy priority. Until 2017, for inpatient care, hospitals were typically paid fixed-rates for long-terms stays of chronic patients. For most hospital stays hospitals got payments per discharge. These depended on the department and were negotiated by HICs and HCPs ([338]). From 2017 on, a diagnostic-related group-linked payment mechanism (DRG) started to be gradually implemented. In 2017, individual hospitals had individual rates in order to avoid significant financial fluctuations and destabilisation of the inpatient sector. Every HIC has its own safety net system, allowing for additional payments should the DRG-based payment substantially deviate from the original payment mechanism (payment for hospitalisation/discharge) of the hospitals. The safety nets ensure stability in payments to individual providers. A five-year convergence process of individual rates to a single nation-wide basic rate will be initiated in 2018 and should be completed by 2022.

Health insurance companies are responsible for contracting hospitals. They sign contracts with health care providers for different quantity of health care services on the basis of selected regional needs. They have the possibility to differentiate the quantity of health care services purchased according to the quality of providers. As of 2018, HICs have introduced payment via global budgets (equal monthly payments based on 6 months average of previous term), which has to be based on DRG reporting. It serves as another safety net to avoid under-financing.

The number of physicians' consultations per capita is well above the EU average (11.4 vs. 6.3 in 2015). When looking at hospital activity, inpatient discharges are higher than the EU average (respectively 19.3 vs. 16.2 per 100 inhabitants) in 2015. Hospital average length of stay for curative care is slightly below the EU average (7.2 days vs. 7.6 days in 2015).

The market for pharmaceutical products, the use of Health Technology Assessment and cost-benefit analysis

Medicines are divided into three categories by law according to their clinical performance and economic evaluation: medicines fully paid by the health insurance; medicines partially paid by the health insurance company and with co-payment by patients; and medicines fully paid by patients. The physician who prescribes the medicines is obliged to inform patients on the reimbursement category, in which a medicine is placed. The pharmacy is obliged to issue the receipt of the amount of overall payment and the private co-payment.

A number of measures have been adopted to control pharmaceutical expenditure. In addition to

([338]) Source: http://hpi.sk/cdata/Publications/hpi_zakladne_ramce_2014.pdf.

price reductions, external reference pricing and a regressive mark-up were introduced in recent years. The initial model was based on the referencing of prices against the average of six lowest prices in the EU. In 2011, referencing was tightened, so that drug prices could not exceed the level of the second lowest price in the EU. As of 2013, prices are referenced at the level of the average of the three lowest prices for a given drug in the EU. Slovakia has established a greater use of generics as a policy priority.

In June 2016, the international reference pricing has been extended to medical devices and specialised medical material. At first 535 medical devices representing 11% of all medical devices were referenced leading to immediate price reduction of about 21% on average compared to prices in the previous year. Selected medical materials (such as pacemakers, stents, and defibrillators) were included as well. Next, in October 2016, the reference pricing was expanded to include all medical materials.

Some groups of medicines that are used in outpatient care are procured centrally by insurance companies (for example, vaccines, oncological medicines, etc.). Hospitals purchase pharmaceuticals on their own from their budgets.

E-Health, Electronic Health Record

During 2017, all doctors were connected to an eHealth environment. Selected eHealth elements, such as a National health portal, ePrescription, eMedication, electronic health documentation and eAllocations, have become functional at the beginning of 2018. However, there are no intentions to fully replace paper-based health documentation with eHealth forms.

Health promotion and disease prevention policies

The need to improve health status further through promotion and prevention activities is a policy priority. Slovakia spends less on prevention and public health services than the EU average (2.2% of public current health expenditure relative to 3.1% in the EU in 2015).

Transparency and corruption

The contracts between HICs and healthcare providers are published online mandatorily. All contracts of state-owned healthcare providers are also mandatorily published online (including public procurement contracts). Online publishing is also used as a tool to put into transparency any interactions among physicians and pharmaceutical companies. The companies have to publish a list of doctors who took part on the organised by them medical congresses and conferences. Since July 2016, companies publish all transfers of value to health care providers (e.g. doctors and nurses), including the name of the health care provider, the value and purpose of the transfer of value (both financial and non-financial) ([339]).

Recently legislated and/or planned policy reforms

Health insurance

The system of risk compensation in public health insurance was extended by adding the morbidity parameter through classification of policy holders in pharmaceutical cost groups (PCG). Since the second half of 2012, the revenues of insurance companies have thus been following real costs of treatment of their policy holders.

Reform of primary care

The average number of patient visits per year in Slovakia is almost twice as much compared with the EU average (11.4 vs. 6.3 in 2015). One reason for this is a poor integration of health care providers which is demonstrated by a high degree of fragmentation of primary health care providers; where 2,933 territorial units ([340]) (municipalities) exist with a total of 2,863 primary care physicians ([341]). The other problem is the high rate of referrals; a high number of patient visits indicates inadequate patient management by primary physicians, where more than 80% of patients with chronic disease are transferred from the first contact with a GP physician directly to a hospital

([339]) http://www.health.gov.sk/Clanok?mz-zavadza-transparentnejsie-pravidla-pri-zverejnovani-vydavkov-farmaceutickych-firiem-na-propagaciu-a-marketing.
([340]) http://www.vlada.gov.sk/slovensko.
([341]) Source : http://www.nczisk.sk/Documents/publikacie/analyticke/zdravotnictvo_slovenskej_republiky_v_cislach_2014.pdf.

specialist. The Ministry of Health has taken actions to proportionally change the redistribution of patients visits from nowadays 80% managed by specialists and only 20% fully managed by GPs to around 60% and 40% in the next few years. Efforts to make the profession of a general practitioner more attractive are continuing, in order to attract young doctors. The Ministry of Health has legislatively defined a new form of preparation of general practitioners already during their university studies, and as from July 2014, GP's have the possibility to perform pre-operation examinations of patients with common diseases. In 2015 legislation was passed allowing GPs broader rights in treating chronic patients, previously treated by specialists (e.g. patients with diabetes).

Improving the financial management and economy of providers

The Slovak Government undertakes measures to ensure that, on average, health care facilities established by the Ministry of Health of the Slovak Republic will operate on a balanced budget without needing additional financial assistance from the state budget and that their indebtedness will be considerably reduced. The indebtedness of state hospitals has not slowed down since 2012 ([342]). Thus, a newly established unit for the management of hospitals operated by the Ministry of Health together with supervisory bodies in hospitals should reinforce surveillance and help improve financial management of state-owned hospitals.

The financial management of hospitals needs to be set in a manner that rewards performance and efficiency. However, prior to introducing performance-based remuneration of executive managers, it is necessary to ensure systematic collection, monitoring and evaluation of the relevant indicators. Correctly set financial management of hospitals may considerably help prevent the accumulation of debts and thus increase the efficiency of spending. Hospital managements should also focus on operational savings by curtailing duplication of processes and personnel.

Savings in the procurement of energy, materials, services and other inputs used by hospitals can be achieved by centralising purchases at the level of hospitals' managements. Furthermore, with the introduction of central procurement, hospitals will be able to spend their funds more effectively without compromising on the treatment of patients. Centralised procurement by the Ministry of Health continues and is already implemented in state-owned hospitals. A framework agreement set up first for the procurement of CT technology, will be now also used for procurement of MRI technology and hospital beds.

Better integration of healthcare provision

One of the planned steps, conducive to stabilise expenditure, is the introduction of an integrated model of health care provision. The position of general practitioners is supposed to be further reinforced in order to reduce more expensive treatment in hospitals and by specialist physicians. The residency programme will bring a new generation of general practitioners and help improve the treatment management process. Medical students will be required to undergo a period of training in outpatient facilities already during their university studies. Following the completion of their study programmes, graduates will be required to work for a certain number of years in outpatient facilities in Slovakia. One of the key components of the integrated model of health care provision will include the application of e-Health in practice.

An insufficient coordination of the current types of establishments in the treatment process often leads to cases where more specialised and costly healthcare provider than medically necessary is dealing with relatively simple medical cases. A clear definition of the types of hospitals and the extent of care provided by them and a better coordination of involvement of outpatient and inpatient facilities in individual stages of treatment could help increase the efficiency in the use of capacities. Hospitals types should be defined according to the extent of healthcare provision. The portfolio of healthcare provision should reflect the variability of cases and the levels of difficulty so that adequate capacity is achieved for the needs

([342]) According to data provided to the Ministry of Finance by the Ministry of Health, in 2012 the indebtedness of hospitals affiliated with the Ministry of Health grew by €93 million, in 2013 by €95 million. In 2014 the rate slowed down to €71 million, but in 2015 it again rose to €108 million. At the end of 2017 total indebtedness reached €791 million.

of the catchment area. At the same time, the coordination between outpatient and inpatient establishments should improve. The aim will be to set the system in a way that will allow providers at each level to be used in individual cases so that staff and physical resources would not be wasted. Particular setting and detailed definitions will be gradually profiled in the Strategic Healthcare Framework for 2014 – 2030 which is an ex ante conditionality for using EU financial resources. In 2018, the Ministry of Health has introduced in cooperation with HICs the stratification plan of hospitals which should reform the current system and implement new set of rules for selective contracting based on evidence-based hospital referral (EBHR – minimal quantitative standard for achieving sufficient quality of care). New hospital typology is crucial in this endeavour and therefore it is important to achieve great consensus on political and also on health care providers level.

Introduction of diagnosis-related group (DRG) payments

With the introduction of diagnosis-related group payments by 2022, it will be possible to identify internal reserves of resources in the public health insurance system, increase transparency in the relations between insurance companies and hospitals and manage them in a meaningful and effective manner. For every hospital case, the DRG system will assign a portion of funds set in advance – based on diagnosis, procedure, age, gender, presence of other diseases or complications and other measurable criteria. If an identical procedure is performed during the treatment of an identical diagnosis, every hospital will receive the same amount from an insurance company. DRG payments will provide a transparent healthcare funding system for in-patient healthcare facilities, thus bringing more fairness to the funding of healthcare providers. The creation of a uniform platform for the funding of the provided hospital services in the form of the DRG system will contribute to the possibility to compare healthcare provided in the individual healthcare facilities, and a broader scope of information will be collected for decision-making and control.

In 2018, hospitals are being reimbursed via global budgets, which represent an equal monthly payment. The budget has to be "filled" from DRGs and if there is a 20% difference between reporting and payments, the HIC or the provider are obliged to start new negotiations. At the same time, a five-year convergence process has been initiated, insuring the transition from individual hospital rates to single nation-wide basic rates in 2022.

Construction of a modern hospital in Bratislava

Along with the adoption of measures aimed at stopping the growing indebtedness of hospitals, investments will be made in acute hospitals which will replace some of the most obsolete and least efficient facilities. The intention to build a new hospital in Bratislava was included in the 2016 government manifesto and will be financed from public funds.

Challenges

The analysis above shows, that a range of reforms have been started/implemented in recent years. However, when it comes to the efficiency of health care provision, Slovakia's performance is relatively low ([343]). The main challenges for the Slovak health care system are as follows:

- To continue increasing the efficiency of health care spending in order to adequately respond to perceived current inefficiencies, such as high spending on ancillary services (diagnostic imaging, laboratories, transportation and medical rescue services), pharmaceuticals and medical goods, as well as the increasing health care expenditure over the coming decades. This is a risk to the long-term sustainability of public finances.

- To introduce an integrated care model, e.g. by establishing health centres and devising and implementing the master plan for an effective geographic distribution of health care resources, by safeguarding accessibility and delivering efficiency gains.

- To further promote the supply of general practitioners by removing the restrictions on the volume and range of primary health services, introducing the performance element to payment schemes, and improving the attractiveness of being a general practitioner.

([343]) http://www.finance.gov.sk/Default.aspx?CatID=8789.

- To ensure balanced hospital budgets by improving the efficient utilisation of resources, hardening budgetary constraints, improving guidance and supervision in procurement processes and enhancing payment systems, by introducing a diagnosis-related groups payment system as planned currently. To continue recent efforts to optimise the utilisation of acute care beds (low bed occupancy rates imply an excess of hospital beds which may lead to inefficiency in the operating costs of hospitals), by introducing effective referral system and control of admissions. To implement stratification of hospitals to increase quality of care and achieve better allocation of resources.

- To implement measures for a comprehensive streamlining of public hospital care, including transforming acute care beds into long-term care beds. A new hospital typologisation can be instrumental in this endeavour and it is therefore important to achieve consensus on political and health care providers level.

- To promote the rational use of medicines by combining different policies, such as electronic prescription, monitoring and guidelines linked with electronic systems and providing feedback to physicians appears an effective way of improving prescription behaviour. This may reduce the risk of over-prescription and wrong co-medication. To introduce a national procurement system for pharmaceuticals in order to enhance the bargaining power of hospitals against pharmaceuticals companies.

- To fully implement and extend the pilot project on ‘e-health’ information tools, including electronic health records and e-referrals, aiming to improve coordination between inpatient and outpatient care and to limit overuse of services and pharmaceuticals.

- To continue to improve data collection and monitoring of inputs, processes, outputs and outcomes so that regular performance assessment can be conducted and used to continuously improve access, quality and sustainability of care.

Table 2.24.1: **Statistical Annex – Slovakia**

General context												EU- latest national data			
GDP	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
GDP, in billion Euro, current prices	39	46	56	66	64	68	71	73	74	76	79	12,451	13,213	13,559	14,447
GDP per capita PPS (thousands)	15.0	16.1	17.7	18.5	17.5	19.0	19.2	19.6	19.8	20.6	21.6	26.8	28.1	28.0	29.6
Real GDP growth (% year-on-year) per capita	6.7	8.4	10.7	5.4	-5.6	4.8	3.4	1.5	1.4	2.6	3.8	-4.7	1.5	0.1	2.0
Real total health expenditure growth (% year-on-year) per capita	:	13.0	16.5	2.4	9.1	2.5	-3.2	4.0	1.8	3.2	-9.5	3.7	0.2	0.2	4.1

Expenditure on health*	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Total as % of GDP	6.9	7.2	7.6	7.3	8.5	8.3	7.8	8.0	8.0	8.1	7.0	10.2	10.1	10.1	10.2
Total current as % of GDP	5.5	5.5	6.5	6.6	6.9	7.2	7.0	7.6	7.5	6.9	6.9	9.3	9.4	9.9	9.9
Total capital investment as % of GDP	1.4	1.7	1.1	0.7	1.6	1.1	0.8	0.3	0.5	1.1	0.1	0.9	0.6	0.2	0.3
Total per capita PPS	769	928	1,206	1,374	1,538	1,585	1,551	1,633	1,671	1,724	1,556	2,745	2,895	2,975	3,305
Public total as % of GDP	5.2	5.0	5.2	5.5	6.1	5.9	5.7	5.6	5.7	5.7	5.6	8.0	7.8	7.8	8.0
Public current as % of GDP	5.1	4.9	5.1	5.4	6.0	5.8	5.6	5.5	5.6	5.6	5.5	7.7	7.6	7.6	7.8
Public total per capita PPS	583	652	833	1,028	1,102	1,120	1,141	1,150	1,191	1,216	1,246	2,153	2,263	2,324	2,609
Public capital investment as % of GDP	0.14	0.13	0.11	0.12	0.12	0.11	0.12	0.10	0.11	0.13	0.13	0.2	0.2	0.2	0.2
Public as % total expenditure on health	75.8	70.2	69.1	74.8	71.7	70.6	73.6	70.5	71.2	70.6	80.0	78.1	77.5	79.4	78.4
Public expenditure on health in % of total government expenditure	18.8	19.3	21.7	18.9	17.3	16.9	17.1	17.2	17.4	16.7	15.7	14.8	14.8	15.2	15.0
Proportion of the population covered by public or primary private health insurance	97.6	96.3	95.5	95.4	95.4	95.4	95.2	95.0	94.6	94.2	93.8	99.6	99.1	98.9	98.0
Out-of-pocket expenditure on health as % of total current expenditure on health	23.6	26.6	27.4	26.1	26.9	27.2	23.6	23.2	23.3	18.0	18.4	14.6	14.9	15.9	15.9

Note: *Including also expenditure on medical long-term care component, as reported in standard internation databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

Population and health status	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Population, current (millions)	5.4	5.4	5.4	5.4	5.4	5.4	5.4	5.4	5.4	5.4	5.4	502.1	503.0	505.2	508.5
Life expectancy at birth for females	78.1	78.4	78.4	79.0	79.1	79.3	79.8	79.9	80.1	80.5	80.2	82.6	83.1	83.3	83.3
Life expectancy at birth for males	70.2	70.4	70.6	70.9	71.4	71.8	72.3	72.5	72.9	73.3	73.1	76.6	77.3	77.7	77.9
Healthy life years at birth females	56.6	54.6	56.1	52.5	52.6	52.0	52.3	53.1	54.3	54.6	55.1	62.0	62.1	61.5	63.3
Healthy life years at birth males	55.2	54.5	55.6	52.1	52.4	52.4	52.1	53.4	54.5	55.5	54.8	61.3	61.7	61.4	62.6
Amenable mortality rates per 100 000 inhabitants*	92	86	102	116	110	105	262	261	262	243	250	64	138	131	127
Infant mortality rate per 1 000 live births	7.2	6.6	6.1	5.9	5.7	5.7	4.9	5.8	5.5	5.8	5.1	4.2	3.9	3.7	3.6

Notes: Amenable mortality rates break in series in 2011.

System characteristics												EU- latest national data			
Composition of total current expenditure as % of GDP	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Inpatient curative and rehabilitative care	1.9	1.5	1.7	1.7	1.8	1.8	1.7	1.7	1.8	1.9	2.0	2.7	2.6	2.7	2.7
Day cases curative and rehabilitative care	0.0	:	0.0	0.0	0.0	0.0	0.0	:	:	0.0	0.0	0.2	0.2	0.3	0.3
Out-patient curative and rehabilitative care	1.2	1.6	1.7	1.6	1.9	1.8	1.8	1.9	1.9	1.5	1.5	2.5	2.5	2.4	2.4
Pharmaceuticals and other medical non-durables	2.2	2.2	2.2	2.2	2.4	2.4	2.2	2.0	2.0	1.9	1.9	1.2	1.2	1.5	1.4
Therapeutic appliances and other medical durables	0.5	0.6	0.6	0.6	0.8	0.8	0.7	0.7	0.7	0.5	0.6	0.3	0.3	0.4	0.4
Prevention and public health services	0.2	0.3	0.4	0.4	0.4	0.5	0.2	0.3	0.2	0.1	0.2	0.3	0.2	0.3	0.3
Health administration and health insurance	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.2	0.4	0.4	0.4	0.4
Composition of public current expenditure as % of GDP															
Inpatient curative and rehabilitative care	1.9	1.2	1.4	1.4	1.5	1.5	1.6	1.6	1.7	1.7	1.8	2.6	2.5	2.5	2.5
Day cases curative and rehabilitative care	0.0	0.0	0.0	0.0	0.0	0.0	0.0	:	:	:	:	0.1	0.2	0.3	0.3
Out-patient curative and rehabilitative care	0.8	1.1	1.2	1.3	1.5	1.3	1.4	1.3	1.4	1.4	1.3	1.8	1.8	1.7	1.8
Pharmaceuticals and other medical non-durables	1.7	1.6	1.5	1.6	1.7	1.7	1.5	1.4	1.3	1.3	1.3	0.9	0.9	1.0	1.0
Therapeutic appliances and other medical durables	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.1	0.1	0.2	0.2
Prevention and public health services	0.1	0.1	0.2	0.2	0.2	0.2	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.3
Health administration and health insurance	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.2	0.3	0.3	0.3	0.3

Source: EUROSTAT, OECD and WHO.

Table 2.24.2: **Statistical Annex - continued – Slovakia**

												EU- latest national data			
Composition of total as % of total current health expenditure	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Inpatient curative and rehabilitative care	34.3%	27.5%	25.6%	25.2%	26.4%	25.2%	24.0%	21.6%	23.8%	27.3%	28.3%	29.1%	27.9%	27.1%	27.0%
Day cases curative and rehabilitative care	0.0%	:	0.0%	0.0%	0.0%	0.0%	0.0%	:	:	0.6%	0.6%	1.7%	1.7%	3.0%	3.1%
Out-patient curative and rehabilitative care	21.4%	29.0%	25.9%	24.6%	28.1%	24.8%	25.5%	24.4%	24.9%	22.0%	22.4%	26.8%	26.3%	23.7%	24.0%
Pharmaceuticals and other medical non-durables	40.6%	40.1%	33.5%	33.6%	35.4%	33.1%	31.3%	26.6%	26.5%	27.0%	26.9%	13.1%	12.8%	14.7%	14.6%
Therapeutic appliances and other medical durables	9.8%	10.3%	9.4%	9.1%	10.9%	10.4%	10.0%	9.1%	9.2%	7.5%	8.4%	3.6%	3.6%	4.1%	4.1%
Prevention and public health services	2.9%	5.9%	5.7%	5.6%	6.1%	6.3%	3.0%	4.2%	2.1%	1.9%	2.2%	2.8%	2.5%	3.0%	3.1%
Health administration and health insurance	5.1%	5.3%	4.2%	4.7%	4.2%	4.0%	3.7%	3.3%	3.4%	4.2%	3.2%	4.5%	4.3%	3.9%	3.8%
Composition of public as % of public current health expenditure															
Inpatient curative and rehabilitative care	36.8%	25.3%	26.6%	26.0%	25.8%	26.6%	28.4%	29.7%	30.4%	31.0%	32.1%	33.9%	33.6%	32.1%	31.9%
Day cases curative and rehabilitative care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	:	:	:	:	1.9%	2.0%	3.4%	3.5%
Out-patient curative and rehabilitative care	15.2%	22.8%	24.3%	24.5%	25.5%	23.3%	24.3%	24.2%	24.9%	24.3%	24.4%	22.9%	23.5%	22.2%	22.5%
Pharmaceuticals and other medical non-durables	32.5%	32.4%	29.4%	29.4%	28.5%	28.7%	27.1%	24.7%	23.8%	24.1%	23.9%	11.8%	11.9%	12.6%	12.7%
Therapeutic appliances and other medical durables	2.8%	3.3%	3.1%	3.2%	3.4%	3.3%	3.6%	3.6%	3.7%	3.8%	4.0%	1.8%	1.9%	2.0%	2.1%
Prevention and public health services	1.8%	2.6%	2.9%	2.8%	3.0%	3.0%	1.6%	1.5%	1.5%	1.8%	2.4%	2.9%	2.5%	3.2%	3.2%
Health administration and health insurance	5.5%	5.9%	5.5%	5.8%	4.9%	5.0%	4.8%	4.6%	4.5%	5.2%	4.0%	4.1%	4.0%	3.6%	3.4%

												EU- latest national data			
Expenditure drivers (technology, life style)	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
MRI units per 100 000 inhabitants	0.43	0.45	0.57	0.61	0.61	0.68	0.70	0.63	0.67	0.83	0.88	1.0	1.4	1.5	1.9
Angiography units per 100 000 inhabitants	0.8	0.7	0.8	0.8	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	1.0
CTS per 100 000 inhabitants	1.1	1.2	1.4	1.4	1.3	1.4	1.5	1.6	1.5	1.7	1.8	2.1	1.9	2.1	2.3
PET scanners per 100 000 inhabitants	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.1	0.1	0.2	0.2
Proportion of the population that is obese	:	:	:	15.1	15.1	:	:	:	:	15.9	:	15.0	15.1	15.5	15.4
Proportion of the population that is a regular smoker	:	:	:	19.3	19.5	:	:	:	:	22.9	:	23.2	22.3	21.8	20.9
Alcohol consumption litres per capita	10.8	10.3	10.6	11.4	10.6	10.1	10.2	10.1	9.9	10.6	:	10.4	10.3	10.1	10.2
Providers	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Practising physicians per 100 000 inhabitants	304	317	300	337	330	336	331	336	339	343	345	324	330	338	344
Practising nurses per 100 000 inhabitants	632	633	662	658	637	640	628	580	580	:	:	837	835	825	833
General practitioners per 100 000 inhabitants	:	:	42	:	:	:	:	:	:	:	:	77	78	78	78
Acute hospital beds per 100 000 inhabitants	690	617	608	559	553	546	535	528	523	524	518	416	408	407	402
Outputs	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Doctors consultations per capita	11.3	10.4	11.2	12.1	11.6	11.6	11.0	11.2	11.0	11.3	11.4	6.2	6.2	6.2	6.3
Hospital inpatient discharges per 100 inhabitants	18	18	17	18	18	18	18	:	:	19	19	17	16	16	16
Day cases discharges per 100 000 inhabitants	:	:	:	:	:	:	:	:	:	0	0	6,362	6,584	7,143	7,635
Acute care bed occupancy rates	67.0	68.0	67.9	67.5	67.3	66.5	65.5	67.3	67.4	68.9	68.7	77.1	76.4	76.5	76.8
Hospital average length of stay	7.3	7.2	8.6	8.5	8.3	8.2	8.0	7.5	:	7.3	7.2	8.0	7.8	7.7	7.6
Day cases as % of all hospital discharges	:	:	:	:	:	:	:	:	:	0.0	0.0	28.0	29.1	30.9	32.3

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP*	**2016**	**2020**	**2025**	**2030**	**2035**	**2040**	**2045**	**2050**	**2055**	**2060**	**2065**	**2070**	**Change 2016-2070, in pps. Slovakia**	**EU**
AWG reference scenario	5.6	5.8	6.0	6.2	6.5	6.6	6.8	6.9	6.9	7.0	6.9	6.8	1.2	0.9
AWG risk scenario	5.6	5.9	6.4	6.9	7.3	7.6	7.9	8.1	8.2	8.3	8.3	8.1	2.6	1.6

Note: *Excluding expenditure on medical long-term care component.

Population projections	**2016**	**2020**	**2025**	**2030**	**2035**	**2040**	**2045**	**2050**	**2055**	**2060**	**2065**	**2070**	**Change 2016-2070, in % Slovakia**	**EU**
Population projections until 2070 (millions)	5.4	5.5	5.5	5.5	5.4	5.4	5.3	5.3	5.2	5.1	5.0	4.9	-9.5	2.0

Source: EUROSTAT, OECD, WHO and European Commission (DG ECFIN)-EPC (AWG) 2018 Ageing Report projections (2016-2070).

Slovakia

Long-term care systems

3.24. SLOVAKIA

General context: Expenditure, fiscal sustainability and demographic trends

GDP per capita in PPS is at 21,600 and below EU average of 29,600 in 2015. Slovakia currently has a population of 5.4 million inhabitants and is projected to reach 4.9 million in 2070, a decrease of 10%, in contrast with an increase in the EU as a whole of 2%.

Health status

Life expectancy at birth for both women and men is respectively 80.2 years and 73.1 years in 2015 and is below the EU averages (83.3 and 77.9 years, respectively). Healthy life years at birth are with 55.1 years (women) and 54.8 years (men) far below the EU-averages (63.3 and 62.6, respectively). The percentage of the Slovak population reporting a long-standing illness or health problem is slightly lower than in the Union (30.4% in Slovakia versus 34.2% in the EU). The percentage of the population indicating a self-perceived severe limitation in its daily activities stands at 9.3%, which is higher than the EU-average (8.1%).

Dependency trends

Dependency is expected to increase in Slovakia. The number of people in dependency is forecasted to increase from 510 thousand in 2015 to 770 thousand in 2070, a 52% change, higher than the increase in the EU (25%). Additionally, the proportion of the population being dependent in terms of severe limitations in daily activities is projected to increase from 9.3 to 15.6%, giving a 68% increase, compared to the more modest EU trend of 21%.

Expenditure projections and fiscal sustainability

When it comes to public expenditure on long-term care as a percentage of GDP, rising trends are expected ([565]). In the "AWG reference scenario", encapsulating health-status and demographic cost drivers, Slovakia's public expenditure is expected to increase from 0.9 to 1.5 pps of GDP until 2070. The "AWG risk scenario", which in comparison to the "AWG reference scenario" captures the impact of additional cost drivers to demography and health status, i.e. the possible effect of a cost and coverage convergence, projects an increase in spending up to 2.9 pps of GDP by 2070. Over the long run, medium sustainability risks appear for the Slovak Republic. These risks derive primarily from the projected impact of age-related public spending (notably healthcare and pensions) ([566]).

System Characteristics

Long term care (LTC) in Slovakia is regulated by separate pieces of legislation. LTC is in the competence of the Ministry of Health in cooperation with the Ministry of Labour, Social Affairs and Family. The Ministry of Labour, Social Affairs and Family is specifically in charge of: 1) compensations of social consequences of a severe disability mainly in the field of self-service including necessary tools, providing monetary contribution for care-taking and monetary contribution for personal assistance; 2) providing or ensuring social services at home, mainly home nursing services. In institutions – providing social services in a social service facility, in an outpatient or hospitalised form, weekly or yearly. Developing an integrated legal framework for LTC remains one of the key policy challenges in Slovakia.

For the moment, there is a poor coordination between health and social long-term care, but lack of coordination is perceptible also between state administration and regional/local administration. There is an acute demand for measures integrating health and social care into one institution.

Based on the 2018 Ageing Report, total public spending on LTC (health and social part) ([567]) reached 0.9% of GDP in 2016 far below EU average of 1.6% of GDP. The low level of funding implies that a considerable part of current LTC needs are not covered by public means. This is supported by the fact, that in 2017, approx. 4,000 dependent people were on waiting lists for social

([565]) The 2018 Ageing Report: https://ec.europa.eu/info/sites/info/files/economy-finance/ip079_en.pdf.

([566]) European Commission, Fiscal Sustainability Report (2018), https://ec.europa.eu/info/sites/info/files/economy-finance/ip094_en_vol_2.pdf.

([567]) Long-term care benefits can be disaggregated into health-related long-term care (including both nursing care and personal care services) and social long-term care (relating primarily to assistance with IADL tasks).

care institutions places. Thus, informal care provided by family members or close non-relatives plays a decisive role in Slovakia ([568]).

In the EU, 50% of dependents are receiving formal in-kind LTC services or cash-benefits for LTC. This share is with 56.3% higher in Slovakia. It means that approximately 1 out of 2 individuals aged 15 or more and declaring themselves as severely dependent, would receive some kind of formal care (at home or in institution, in-kind or in cash). Slovakia seems to have below the average usage of cash benefits compared to the EU. In fact, 11% of public LTC spending is done via cash benefits (EU: 15.6%), while the majority of the public expenditure on LTC are devoted to in-kind benefits (89%).

The expenditure for institutional services makes up 48.6.% of public expenditure on LTC in-kind benefits (EU: 66%), 51.4% being spent for LTC in-kind services provided at home (EU: 33%). Thus, within its relatively low spending envelope, relative to other Member States Slovakia has a focus on home care.

Types of care, eligibility criteria and user choices: dependency, care needs, income

LTC in the area of health is provided in the form of geriatric care in outpatient departments, specialised hospital departments, day care centres, home nursing agencies, hospices and other facilities. Day care centres and nursing homes are financed from public health insurance resources. Senior and specialised homes belong to the competence of the Ministry of Labour, Social Affairs and Family and are financed by municipalities, payments from clients and subsidies of the Ministry of Labour, Social Affairs and Family.

Social LTC benefits are provided in the form of in-kind and cash benefits. Social services are financed by local and regional self-governments, state subsidies, and payments by care recipients. Cash benefits are financed by the State and provided through a network of local offices of labour, social affairs and family.

Legislation defines the minimum duration of a functional disease and the minimum degree of dependence for the provision of the various benefits. The entitlement to cash benefits is means-tested. The recipients' income and assets are taken into account in the eligibility of public benefits. Co-payments apply for recipients of benefits in-kind usually up to the level of "economically justified" costs. The entitlement to and level of cash benefits are subject to a person’s income and assets not exceeding a certain ceiling. Higher income thresholds are applied to benefits for children needing care. Benefits in-kind (social service) are also subject to a means test, but under a different procedure. The income shall be considered as the total income excluding one-off state social benefits, child benefit, tax bonuses, scholarships etc. Assets are not counted e.g.: property used for permanent housing, land for own use, or car used by severely disabled persons. The cash benefit is reduced as income increases and when income is over 5-times the subsistence minimum, the cash benefit is withhold.

Payment for social services to the level of economically justified costs only relates to the provision of social services and not to compensations. In all-year residential facilities of social services, the law regulates an income protection up to 25% of living wage. In case of home nursing service, there is a guaranteed income balance amounting at 1.4 times the living wage.

Social services in Slovakia, including long-term care, are decentralised and are financed from the budgets of municipalities and higher territorial units. An amendment to the Act on Social Services which came into force on 1.3.2012 introduced also direct state participation in the financing of particular types of social services (mostly long-

([568]) As explained in footnote (3) there are LTC expenditures that are not included in this number, and which, for the purposes of Ageing Report 2018 were estimated through building a proxy from separate ESSPROS (European System of integrated Social Protection Statistics) data. In particular, a large share of the in-kind benefits of the Ministry of Labour, Social Affairs and Family or the municipalities are not classified as expenditures on LTC in the SHA, though they should be considered LTC expenditure according to the definition bellow (page 1&2). However, there is no clear concept of LTC in Slovakia and therefore it is difficult to define which of these expenditures should be included and also to quantify the impact using a national methodology. For example, there are homes of social services that provide other kind of services apart from the long-term care but this is not distinguished in the statistics.

term care) belonging to the municipalities and private providers of social services at the municipal level. The Ministry of Labour, Social Affairs and Family gives to the providers of social services normative financial contribution in a fixed amount. The amount depends on the type of social services, e.g. contribution for a client in a facility for elderly persons is €320 per month; contribution for a client in a facility-supported living is €200 per month. This expenditure only has partial impact on the LTC expenditure level according to the SHA classification.

Prevention and rehabilitation measures

The system of social services encompasses facilities and activities focused on social prevention and rehabilitation and support to independent living (e.g. rehabilitation centres, daily care stations, specialised activities such as ergo-therapy, access to ICT and cultural events, social counselling). Compensatory cash benefits enable disabled persons to adjust their housing or improve mobility to reduce dependence on other person's assistance. However, preventive and rehabilitative activities comprise only a minor part of social LTC.

Formal/informal caregiving

There are four major classes of LTC carers:

(1) Informal carers - nearly 60,000; they receive cash benefits for care, whereas only about 2% are working at the same time. During the caregiving period, the health and pension insurance is being paid by the state and they are entitled to use public supportive services, which are currently used marginally. Families are mostly reluctant to use professional LTC services if they are able to provide care "on their own".

(2) Home nursing - done by approx. 6,300 employees of municipalities or private providers. The extent of the service depends on the client's needs that are assessed by a medical expert. Home nursing is funded from the health insurances.

(3) Personnel within residential care - circa 18,000 employees in permanent residential care in different types of social services for adults and seniors; short-term services (care on a daily or weekly basis ([569])) are used only occasionally.

(4) Volunteers – only registered at non-public residential providers, in 2008-2010 they represented nearly 30% of workers working for private providers of LTC.

Recently legislated and/or planned policy reforms

The crucial role of informal (family) care for providing long-term care services in Slovakia is generally acknowledged. However, policy reforms in the past years were targeted almost exclusively on the formal sector of LTC, and improvement of informal care is still outstanding. In 2018, the Ministry of Health introduced additional nursing services in social residential facilities (such as treatment of bedsores, positioning the patient, application of drugs, nursing rehabilitation, etc.) to be reimbursed by the health insurances. However, the reimbursement for nursery care in residential homes from health insurances is linked to a minimum level of bed capacities in municipalities, set by the Ministry of Health and effective from January 2018.

The Institute of Health Policy of the Ministry of Health currently co-operates with the Ministry of Labour, Social Affairs and Family to prepare a strategy for LTC. The strategy aims to create the optimal integrated model of LTC care. The National Programme for Active Ageing 2014-2020, approved by a government resolution in 2013, gives the possibility to introduce insurance for LTC by 2020 by the Ministry of Labour, Social Affairs and Family in cooperation with the Ministry of Finance. The strategy of de-institutionalisation of social services and strengthening of care, approved by a government resolution end-2011, foresees a systemic transition from institutional to community-based care ([570]). It

([569]) Providing LTC is not yet based on a comprehensive legislative framework (see planned policy reforms), such that the types of care are not precisely defined. This issue falls within the competence of the Ministry of Health.

([570]) Piloting de-institutionalisation is the main goal of a project called "Supporting the process of de-institutionalisation and transformation of the social services system –NP DI". The Ministry of Labour ran the project from 2013 to 2015. The project was successfully finished and will be followed by two other projects cofounded by the EU structural funds.

includes limits on capacity of institutions and restrictions on the year-round provision of care in certain types of facilities (e.g. homes of social services shall provide only care on a daily or weekly basis). In addition, new types of services aim to support independent living of persons with disabilities and strengthen social prevention and early intervention.

Challenges

The main challenges of the system appear to be:

- **Improving the governance framework**: to establish a coherent and integrated legal and governance framework for a clear delineation of responsibilities of state authorities with respect to the provision of long-term care services; to set the public and private financing mix and organise formal workforce supply to face the growing number of dependents, and provide a strategy to deliver high-performing long-term care services to face the growing demand for LTC services; to strategically integrate medical and social services via such a legal framework; to define a comprehensive approach covering both policies for informal (family and friends) carers, and policies on the formal provision of LTC services and its financing; to establish good information platforms for LTC users and providers.

- **Improving financing arrangements**: to face the increased LTC costs in the future e.g. by tax-broadening, which means financing beyond revenues earned by the working-age population; to foster pre-funding elements, which implies setting aside some funds to pay for future obligations; to explore the potential of private LTC insurance as a supplementary financing tool.

- **Encouraging home care:** to develop alternatives to institutional care by e.g. developing new legislative frameworks encouraging home care and regulation controlling admissions to institutional care or the establishment of additional payments, cash benefits or financial incentives to encourage home care; to monitor and evaluate alternative services, including incentives for use of alternative settings.

- **Ensuring availability of formal carers:** to determine current and future needs for qualified human resources and facilities for long-term care.

- **Supporting family carers:** to establish policies for supporting informal carers, such as through flexible working conditions, respite care, carer's allowances replacing lost wages or covering expenses incurred due to caring, cash benefits paid to the care recipients, while ensuring that incentives for employment of carers are not diminished and women are not encouraged to withdraw from the labour market for caring reasons.

- **Facilitating appropriate utilisation across health and long-term care:** to arrange for adequate supply of services and support outside hospitals, changing payment systems and financial incentives to discourage acute care use for LTC; to steer LTC users towards appropriate settings.

- **Improving value for money:** to invest in ICT as an important source of information, care management and coordination.

- **Prevention:** to promote healthy ageing and preventing physical and mental deterioration of people with chronic care; to employ prevention and health-promotion policies and identify risk groups and detect morbidity patterns earlier.

Table 3.24.1: **Statistical Annex – Slovakia**

GENERAL CONTEXT

GDP and Population	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU 2009	EU 2011	EU 2013	EU 2015
GDP, in billion euro, current prices	39	46	56	66	64	68	71	73	74	76	79	12,451	13,213	13,559	14,447
GDP per capita, PPS	15.0	16.1	17.7	18.5	17.5	19.0	19.2	19.6	19.8	20.6	21.6	26.8	28.1	28.0	29.6
Population, in millions	5.4	5.4	5.4	5.4	5.4	5.4	5.4	5.4	5.4	5.4	5.4	502	503	505	509
Public expenditure on long-term care (health)															
As % of GDP	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.1	1.2	1.2	1.2
Per capita PPS	:	:	:	:	:	:	:	5.3	5.2	5.1	5.3	264.1	283.2	352.1	373.6
As % of total government expenditure	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.1	0.1	0.0	0.1	1.6	1.8	2.5	2.5
Note: Based on OECD, Eurostat - System of Health Accounts															
Health status															
Life expectancy at birth for females	78.1	78.4	78.4	79.0	79.1	79.3	79.8	79.9	80.1	80.5	80.2	82.6	83.1	83.3	83.3
Life expectancy at birth for males	70.2	70.4	70.6	70.9	71.4	71.8	72.3	72.5	72.9	73.3	73.1	76.6	77.3	77.7	77.9
Healthy life years at birth for females	56.6	54.6	56.1	52.5	52.6	52.0	52.3	53.1	54.3	54.6	55.1	62.0	62.1	61.5	63.3
Healthy life years at birth for males	55.2	54.5	55.6	52.1	52.4	52.4	52.1	53.4	54.5	55.5	54.8	61.3	61.7	61.4	62.6
People having a long-standing illness or health problem, in % of pop.	:	27.5	27.3	29.6	29.5	30.7	31.6	29.8	30.7	30.3	30.4	31.3	31.7	32.5	34.2
People having self-perceived severe limitations in daily activities (% of pop.)	:	11.1	10.4	11.2	10.8	10.4	10.2	10.0	9.6	9.9	9.3	8.3	8.3	8.7	8.1

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU 2009	EU 2011	EU 2013	EU 2015
Number of people receiving care in an institution, in thousands	:	:	:	10	20	30	31	31	45	46	46	3,433	3,851	4,183	4,313
Number of people receiving care at home, in thousands	:	:	28	34	41	47	48	49	62	62	63	6,442	7,444	6,700	6,905
% of pop. receiving formal LTC in-kind	:	:	0.5	0.8	1.1	1.4	1.5	1.5	2.0	2.0	2.0	2.0	2.2	2.2	2.2
Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients															
Providers															
Number of informal carers, in thousands	44	49	51	50	54	57	58	:	:	:	:	:	:	:	:
Number of formal carers, in thousands	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:

Source: EUROSTAT, OECD and WHO.

Table 3.24.2: **Statistical Annex - continued – Slovakia**

PROJECTIONS

Population	**2016**	**2020**	**2030**	**2040**	**2050**	**2060**	**2070**	**MS Change 2016-2070**	**EU Change 2016-2070**
Population projection in millions	5.4	5.5	5.5	5.4	5.3	5.1	4.9	-10%	2%
Dependency									
Number of dependents in millions	0.51	0.53	0.62	0.69	0.73	0.76	0.77	52%	25%
Share of dependents, in %	9.3	9.7	11.3	12.9	13.8	15.0	15.6	68%	21%
Projected public expenditure on LTC as % of GDP									
AWG reference scenario	0.9	0.9	1.1	1.2	1.4	1.5	1.5	64%	73%
AWG risk scenario	0.9	1.0	1.2	1.5	1.9	2.4	2.9	222%	170%
Coverage									
Number of people receiving care in an institution	49,586	52,623	64,777	78,157	86,026	95,890	102,655	107%	72%
Number of people receiving care at home	67,645	69,155	70,090	68,589	64,564	58,282	52,284	-23%	86%
Number of people receiving cash benefits	167,390	176,660	203,021	223,848	236,590	246,036	242,100	45%	52%
% of pop. receiving formal LTC in-kind and/or cash benefits	5.2	5.5	6.2	6.9	7.4	7.8	8.1	55%	61%
% of dependents receiving formal LTC in-kind and/or cash benefits	56.3	56.1	54.9	53.7	53.3	52.4	51.8	-8%	33%
Composition of public expenditure and unit costs									
Public spending on formal LTC in-kind (% of tot. publ. spending LTC)	88.9	88.6	88.8	89.1	89.2	89.5	89.8	1%	5%
Public spending on LTC related cash benefits (% of tot. publ. spending LTC)	11.1	11.4	11.2	10.9	10.8	10.5	10.2	-8%	-27%
Public spending on institutional care (% of tot. publ. spending LTC in-kind)	48.6	49.5	53.6	58.4	62.4	66.9	70.2	44%	0%
Public spending on home care (% of tot. publ. spending LTC in-kind)	51.4	50.5	46.4	41.6	37.6	33.1	29.8	-42%	-1%
Unit costs of institutional care per recipient, as % of GDP per capita	42.8	42.5	44.4	44.6	46.0	46.5	44.6	4%	10%
Unit costs of home care per recipient, as % of GDP per capita	33.2	32.9	35.4	36.2	36.9	37.8	37.3	12%	1%
Unit costs of cash benefits per recipient, as % of GDP per capita	3.3	3.3	3.3	3.3	3.2	3.2	3.1	-6%	-14%

Source: EUROSTAT, OECD, WHO and European Commission (DG ECFIN)-EPC (AWG) 2018 Ageing Report projections (2016-2070).